CHAPTER V

BILLING PROCEDURES

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BILLING FOR PHARMACY SERVICES

To bill the Virginia Medicaid Program for pharmaceutical services provided to recipients, a provider may use the Daily Pharmacy Drug Claim Ledger (DMAS-173). In the case of home I.V. services, the HCFA-1500 (12-90) must be used. Adjustments to paper claims already paid must be submitted on the Daily Pharmacy Drug Claim Ledger Adjustment (DMAS-228, R 9/78) or the HCFA-1500 (12-90) as appropriate. Copies of these forms and instructions for completion are presented later in this chapter.

If a claim has been denied or rejected, make the necessary corrections and resubmit the claim. If a payment has been made and changes are necessary, submit an adjustment; do not rebill. This applies to claims using the ten-digit National Drug Code (NDC) on the DMAS-173 R9/78 form or a DMAS non-specific drug code. On DMAS-173 R2/01, the NDC is reported in eleven-digit form.

Providers shall bill the Virginia Medicaid Program their usual and customary charges for all prescriptions dispensed. The Medicaid claims processing system will calculate the reimbursement due according to the rules described in Chapter IV of this manual.

The National Drug Code (NDC) assigned by the manufacturer or distributor found on the package label must be used when billing the Virginia Medicaid Program. Hyphens in an NDC are not recognized in the DMAS processing system. If an NDC is not printed on the label but a Universal Product Code (UPC) is shown for a non-legend drug, the UPC may be used as the drug code after verifying with the HELPLINE that the code is on DMAS' drug file.

For a multiple source drug (VMAC or HCFA) with maximum cost reimbursement limits where the physician has written in his or her own handwriting “Brand Necessary,” the NDC identifying the brand name product dispensed is used, and on DMAS-173 R9/78 an “X” is entered in the Brand Necessary block. DMAS-173 R2/01 requires entry of the number “1” in the “Brand Necessary” field. If “Brand Necessary” is not written on the prescription, the NDC must identify the less expensive generic product actually dispensed, not the brand name product.

Effective for the dates of service on or after September 1, 2002, copayment amounts shall be as follows:

One dollar ($1.00) copay for generic drug products; and
Two dollars ($2.00) copay for single source or “Brand Necessary” products.

THIRD PARTY LIABILITY (TPL) COLLECTIONS FOR POS CLAIMS

In order to conserve Medicaid dollars, and as payer of last resort on pharmacy claims, DMAS is beginning a process of Coordination of Benefits (COB) for Third Party Liability (TPL) collection at the point of service. For pharmacy claims having a service date on or after July 1, 2002, DMAS will send an on-line claim denial message to pharmacy providers submitting POS claims for which the patient has other insurance coverage. The messages used in this project are shown in the table below.

VA Code	Virginia Denial Message Text	NCPDP Code	NCPDP Reject Message Text
313	Bill Any Other Available Insurance	41	Submit Bill To Other Processor Or Primary Payer
387	Primary Carrier Payment Needs Explanation	13	Missing/Invalid Other Coverage Code

DMAS requests that providers receiving either of these messages verify whether the patient has additional coverage. If the patient acknowledges such coverage, the pharmacist should submit the claim first to that third party. Once the other insurer adjudicates the claim, the claim may be resubmitted to DMAS using appropriate messages in NCPDP data element fields, "OTHER COVERAGE CODE" and "OTHER PAYER AMOUNT". These fields are included in existing payer specifications. In order to submit an over ride to the denial, the pharmacist must use the appropriate response in each field as shown below. In the case where a patient denies having additional coverage, the responses to be used in these fields are also noted below.

The pharmacy TPL editing is based on the NCPDP "Other Coverage Code" standard values (Version 3.2). These values and their definitions are as follows:

0 - Not specified
1 - No other coverage identified
2 - Other coverage exists - payment collected
3 - Other coverage exists - this claim not covered
4 - Other coverage exists - payment not collected

Below is a grid reflecting the combination of Other Coverage Code, presence or absence of a third party payment amount and whether or not the recipient's record indicates third party pharmacy coverage with the proposed corresponding claim disposition.

Other Coverage Code	*TPL Amt*	*TPL indicated on Recipient's record*	*Initial Claim Disposition*	*Override process*
0 = Not Specified	0	Yes	Deny, Bill Other Carrier VA code 313/NCPDP code 41	Provider can resubmit with an Other Coverage Code of 3 or 4 as appropriate.

Other Coverage Code	*TPL Amt*	*TPL indicated on Recipient's record*	*Initial Claim Disposition*	*Override process*
0 = Not Specified	0	No	Pay	
0 = Not Specified	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount.
1 = No Other Coverage Identified	0	Yes	Deny, Bill Other Carrier VA code 313/NCPDP code 41	Provider can resubmit with an Other Coverage Code of 3 or 4 as appropriate.
1 = No Other Coverage Identified	0	No	Pay	
1 = No Other Coverage Identified	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount.
2 = Other coverage exists, payment collected	0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or TPL Amount.
2 = Other coverage exists, payment collected	>0	Yes or No	Pay	Payment = Calculated Amount minus Other Payer Amount
3 = Other coverage exists, this claim not covered	0	Yes or No	Pay	This code should be used when the drug is not covered by the other carrier
3 = Other coverage exists, this claim not covered	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code if wrong code entered or enter zeros in TPL Amount if Other Coverage Code was entered correctly.
4 = Other coverage exists, payment not collected	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount.

Other Coverage Code	*TPL Amt*	*TPL indicated on Recipient's record*	*Initial Claim Disposition*	*Override process*
4 = Other coverage exists, payment not collected	0	Yes or No	Pay	This code should be used when the drug is covered by the other carrier but the pharmacy has not been able to collect from the other resource.

If a patient denies having other coverage, the pharmacist should use the appropriate override codes and fill the prescription as if it were a "pay and chase" claim. Until future notice, such claims will be handled under the "pay and chase" waiver. Pharmacists are requested to make every effort to capture TPL payments where possible in order to maximize the potential cost savings to the Medicaid program.

Virginia Medicaid, always the payer of last resort, will only pay claims to the maximum of the Virginia Medicaid Allowed Amount. The coordinated benefit payment of the TPL amount and any additional Medicaid payment will be equivalent to the appropriate payment allowed under DMAS payment rules. Therefore, the total payment may not appear to correspond to the submitted claim amount. The final adjudication under Medicaid will show the appropriate co-pay to be collected from the patient.

For claims submitted using other media, pharmacy providers are requested to attempt to determine if such TPL coverage exists. Using the proprietary format of the DMAS-173 R2/01, use of fields 23 and 24 will capture the desired elements. While these are optional elements at present, they will be mandated upon implementation of the new MMIS system. Immediate pharmacist participation in this effort will assist in the DMAS cost-savings initiatives.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which are not submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the claim on paper with the appropriate attachments. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period

can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a dated letter from the local Department of Social Services (LDSS) which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the dated letter from the LDSS indicating the delayed claim information must be attached to the claim. On the HCFA-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Rejected or Denied Claims** - Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the invoice as explained elsewhere in this chapter.

  - Attach written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  - Indicate Unusual Service by entering "22" in Locator 24D of the HCFA-1500 (12-90) claim form if applicable.

  - Submit the claim in the usual manner by mailing the HCFA claim form to:

    Department of Medical Assistance Services
    Pharmacy
    P. O. Box 27445
    Richmond, Virginia 23261-7445

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

BILLING INSTRUCTIONS

Effective July 1, 2002, Virginia Medicaid will begin utilizing new paper forms for claims related to pharmacy services. These have been developed for use in the new Medicaid Management Information System (MMIS) system, which is scheduled for implementation in 2003. A transition period has been developed to allow providers the opportunity to use up old paper forms and become accustomed to the new one.

The new form is a revised Pharmacy Claim Form (DMAS-173 R2/01). Ultimately, these claim forms will also be used for adjustments and voids of pharmacy claims. This will not occur until additional notice and instructions are provided.

The new forms are single page individual forms. They are not tractor-fed. The forms are printed in "red drop-out" ink which allows them to be processed through a scanner, rather than having to be entered by operators into the system. This format will speedup processing and should improve the timeliness of claims resolution.

Because the scanners operate only when the forms are printed in this special ink, it will not be possible for providers to make copies of the form to be used as back-up to the supplied forms. Please be sure to order forms from Commonwealth Martin in adequate time for your needs.

Pharmacy Claim Form (DMAS-173 R9/78) may be used until supplies have been exhausted, but no later than October 31, 2002. Continue to use the instructions and data string lengths as instructed on the form. That form will not be accepted on and after November 1, 2002.

Directions for new Pharmacy Claim Form (DMAS-173 R2/01) appear on the back of the claim form and may be found in the "Exhibits" section at the end of this chapter. Please note there are some corrections in the instructions to be followed until implementation of the new system.

Virginia Department of Medical Assistance Services
Pharmacy Claim Form (DMAS-173 R2/01)

Required Fields **for new forms** as of 7/1/02 - Note: These will be updated when the new system is implemented.

Field Number	**Description**	**Required (*) as of 7/1/02**
1	Medicaid Pharmacy Provider Number	*
2	Patient's Name (Last, First)	*
3	12-digit Medicaid Patient ID	*
4	Patient's Sex	*
5	Patient's Birth Date	
6	**CORRECTION:** Level of Service	* - only if Emergency **(2)**
7	Days Supply	*
8	**CORRECTION:** New Prescription = **0**; Refill = **0 to 9** (Until new instructions are received, continue to use **9** as an indication that Unit Dose reimbursement is being requested.)	*
9	"Brand Necessary" (According to Medicaid)	*- only if brand dispensed (1)
10	Patient's location	* - only if Nursing Home (03)
11	Adjustment/Void - NA at This Time	NA
12	Adjustment/Void Reference # - NA	NA
13	**CORRECTION:** 6-digit Rx Number will be used until implementation of the new system.	*
14	Date Dispensed (MMDDCCYY)	*
15	**CORRECTION:** 10-digit NDC of Product Dispensed will be used until the new system is implemented.	*
16	Metric Quantity - **(No Decimals Until Notice)**	*
17	Unit Dose Code	* - only if Unit Dose for Nursing Home (4)
18	**CORRECTION**: Exemption Indicator	* - only if Pregnancy (**PG**)
19	11-digit Prior Authorization Number	
20	Valid Prescriber's Medicaid Provider ID #	*
21	ICD-9 Diagnosis Code	(see notes below)
22	Usual & Customary Charge	*
23	Coordination of Benefits Code	
24	Dollar Amount Paid by Primary Payer	
25		*- if needed (note attachment, special required information [such as orlistat clarification], compound ingredients, etc.)
26	Pharmacy Name, Address & Phone #	*

Field Number	Description	Required (*) as of 7/1/02
27	Sign and Date Certification Form	*
	Include Attachments if Necessary	*

Special information for current pharmacy claims submission:

1. Until the new MMIS system is implemented, certified unit dose providers must continue to verify daily delivery of 24-hour unit dose distribution services by use of "9" in Field Number 8.

2. Until the new MMIS system is implemented, forms will be used only for claims submission; therefore, fields 11 and 12 will not be used until that time.

3. Until the new MMIS system is implemented, decimal quantities will not be accepted in the quantity field. Notice will be given when to use decimal quantities. In computing the total quantity in the current system, please multiply the decimal quantity per unit by the number of units dispensed. Round off the total.

4. Unit dose dispensing units provided in a 24-hour distribution system should be documented by the use of a "4" in Field Number 17.

5. Documentation of Prior Authorization must be attached to the claim for products being used for weight loss.

6. Only if the prescriber's Medicaid provider ID number is not included in the published list, the following numbers may be used as necessary:

   - Out-of-State, Non-enrolled provider 9992227
   - In-State, Non-enrolled provider 9994441
   - Non-enrolled provider, Resident in a teaching hospital 9996664
   - Enrolled provider, Identification number not published 9998888

7. Until the new MMIS is implemented, do not bill other insurance carriers for claims submitted on paper. The initiative is for on-line POS claims at this time. Providers will be instructed when any change occurs in this policy.

8. Until the new MMIS is implemented, use field 25 to enter the words "Used for high cholesterol" when submitting claims for orlistat being used to treat hypercholesterolemia. This field may also be used to document compound prescriptions or indicate attachments.

CORRECTED INSTRUCTIONS WILL BE GIVEN PRIOR TO IMPLEMENTATION OF THE NEW MMIS.

BILLING INSTRUCTIONS - DAILY PHARMACY DRUG CLAIM LEDGER (DMAS-173 R9/78)

The Daily Pharmacy Drug Claim Ledger is designed to be completed daily. Each block on the form must be completed correctly with the required information to receive payment for services provided and to avoid delays in processing the claim. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

The instructions for completing each block on this form are as follows:

Block 1 **Transmission Code** - This block is preprinted and requires no entry from the provider.

Block 2 **Pharmacy ID Number** - Enter the seven-digit provider identification number assigned by the Virginia Medicaid Program, if not preprinted.

Block 3 **Date of Service** - Enter the date the prescription(s) was dispensed in MMDDYY format. For example, if the prescription was dispensed on January 1, 1999, the proper entry is 010199. **The date of service must identify the actual date the prescription was dispensed** with the exception of for unit-dose dispensing.

For unit-dose dispensing, enter the last day of the month if the service was rendered during the entire month or if the patient was admitted during the month. Enter the last day the service was rendered if the patient left the facility during the month.

Block 4 **Patient ID Number** - Enter the 12-digit Virginia Medicaid identification number assigned to the recipient receiving the prescription. This number must be entered exactly as it appears on the Medicaid ID card.

Block 5 **Prescription Number** - Enter the six-digit non-duplicated prescription number assigned by the pharmacy.

Block 6 **Drug Code** - Enter the ten-digit (including zeroes) National Drug Code (NDC) as printed on the drug package label (ten digits, **no hyphens**). If an NDC code is not available, the appropriate non-specific code listed below may be entered.

To define a ten-digit NDC Code from an eleven-digit original:
Group the eleven digits as follows, 5-4-2. The first set of digits defines the manufacturer/labeler; the second set defines the product (including strength and dosage form); the third set defines the package size. Your object is to delete the first leading 0 in a grouping, so look at the group of 5 digits first. If the first digit is a 0, delete it. If it is not a 0, proceed to the grouping of 4 digits. If

the first digit is a 0, delete it. If not, move to the group of 2 digits. If the first digit is a 0, delete it. If it is not 0, then the last digit will be 0. Delete it.

Deleting a 0 from any other place will create an inaccurate 10-digit NDC.

9999999100 Legend Drug - Identify the drug name/manufacturer in the bottom portion of the claim.

9999888100 OTC Drug (applicable only for **nursing facility residents, family planning items, and diabetic supplies**) - Identify the drug name/manufacturer in the bottom portion of the claim.

The following codes are to be used for compound prescriptions:

9999888200 Compound prescription with only OTC ingredients (restricted to **nursing facility** residents only)

9999999200 Compound prescriptions with at least one legend drug ingredient in a quantity that represents a therapeutic dose. **Note:** Ingredients such as menthol and phenol will not qualify the prescription for coverage under this drug code.

This number is not to be used for Home IV therapies, including TPN. Service day rates for Pharmacy Home IV therapies have been established and must be billed on the HCFA 1500 form, using the appropriate HCPC Z-code. Only the active ingredient is billed on the pharmacy daily claim form, as explained in Chapter IV.

For **compound prescriptions,** the drug name, NDC number, manufacturer, strength, and quantity must be identified for each ingredient on the bottom portion of the claim form or on an attachment. If by attachment, note "see attachment" in the explanation section with appropriate line number indicated.

Do not itemize ingredient costs for compounded IVs provided to patients receiving drug therapies in a home setting. See instructions for billing the Service Day Rate on the HCFC 1500 form elsewhere in this chapter.

Block 7 **Metric Quantity** - Enter the quantity dispensed using three digits with no decimals or fractions. Note the reporting units described below:

- **Tablets, capsules, suppositories, and inserts** - Enter the number of tablets, capsules, etc., dispensed.
- **Liquids, ampules, and vials IN SOLUTION and oral liquids in powder to be diluted** - Enter the total number of milliliters (mls) or cubic centimeters (ccs) dispensed, rounding only the total volume.
- **Creams, ointments, and powders** - Enter the **number of grams** dispensed.
- **Packages or units, including enemas, vials for injections in powder form, and kits** - Enter the number of packages, units, etc., dispensed.
- **Quantities greater than 999 mls or ccs** - Enter 999 in the quantity field, and the specific NDC assigned to the drug and describe the drug product and the exact quantity dispensed using the bottom portion of the claim form.

Block 8 **New/Refill (N/R)** - Enter one of the following codes, as appropriate:

0 New prescription
1 First refill
2 Additional refill
9 Unit-dose dispensing - Applies to certified unit-dose providers with 24-hour supply delivery

Block 9 **Charge** - Enter the pharmacy's usual and customary charge for the prescription.

Block 10 **Prescriber's DMAS ID** - Enter the prescribing physician's seven-digit Virginia Medicaid provider number. **A valid number must be included for payment to be approved.** If the prescriber number is not on the published list of prescribing provider numbers, enter the appropriate default in Block 10.

Out-of-State, Non-enrolled provider	9992227
In-State, Non-enrolled provider	9994441
Non-enrolled provider, Resident in a teaching hospital	9996664
Enrolled provider, Identification number not published	9998888

Block 11 **Brand Necessary (B/N)** - Enter an "X" in this block **only** when the prescribing physician certifies "Brand Necessary" in his or her own handwriting on a prescription for a brand name drug that identifies with a FUL or VMAC drug.

Unnumbered Block **Pharmacist's Use Block** - This block is to be used in the following circumstances:

- When a restricted recipient has a prescription filled by a pharmacy other than the designated pharmacy. In this case, the non-designated pharmacy enters the letters "ER" in the left side of the Pharmacist's Use block adjacent to Block 11 and in the bottom portion of the claim writes a description of the life-threatening emergency or includes the designated pharmacy's Medicaid ID number and an explanation of why the prescription was filled.

- When the claim is for a pregnancy-related drug and the prescribing physician has so indicated on the prescription. In this case, the pharmacy enters the letters "PG" in the left side of the Pharmacist's Use block adjacent to Block 11. This will prevent the claims payment system from automatically deducting a copayment amount for this prescription. The pharmacist must not collect a copayment from the recipient for these prescriptions. This exemption does not apply after the pregnancy is terminated.

Unnumbered Space **Signature and Date** - Enter the signature of the provider or the provider's agent and the date signed.

BILLING INSTRUCTIONS - ADJUSTMENT (DMAS-228 R 9/78)

The Daily Pharmacy Drug Claim Ledger Adjustment Invoice (DMAS-228 R9/78) is used to change or to void a paid claim only. To change a claim, the provider must check the adjustment box and complete and submit the adjustment form the way the original claim **should have been** completed. This will cause the Medicaid claims processing system to recompute the payment and to reimburse to or recoup from the provider the net difference between the original and the adjusted claim.

To void a claim, the provider must check the void box and complete and submit the adjustment form exactly the way the original claim was submitted. This will cause the claims payment system to void the original claim and recoup the original paid amount from the provider. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

The instructions for completing each block on this form are as follows:

Block 1 **Adjustment/Void** - Enter an "X" in the appropriate box to indicate the action to be taken (either adjustment or void).

Block 2 **Pharmacy ID Number** - Enter the seven-digit provider identification number assigned by the Virginia Medicaid Program.

Block 3 **Date of Service** - Enter the date the prescription was dispensed in MMDDYY format. For example, if the prescription was dispensed on January 1, 2002, the proper entry is 010102.

Block A **Reference Number** - Enter the reference number listed on the remittance voucher for the paid claim being adjusted.

Block B **Reason** - Leave this field blank.

Block C **Input Code** - Leave this field blank.

Block 4 **Patient ID Number** - Enter the 12-digit Virginia Medicaid identification number assigned to the recipient receiving the prescription. This number must be entered exactly as it appears on the Medicaid ID card.

Block 5 **Prescription Number** - Enter the six-digit prescription number assigned by the pharmacy.

Block 6 **Drug Code** - Enter the ten-digit National Drug Code (NDC) for the drug dispensed or the non-specific DMAS drug code.

Block 7 **Metric Quantity** - Enter the quantity dispensed using three digits with no decimals or fractions.

Block 8 **New/Refill (N/R)** - Enter one of the following codes, as appropriate:

0 New prescription
1 First refill
2 Additional refill
9 Unit-dose dispensing - Applies to certified unit-dose providers with 24-hour supply delivery

Block 9 **Charge** - Enter the pharmacy's usual and customary charge for the prescription, **not** the difference in the charge and the amount paid.

Block 10 **Prescriber's DMAS ID** - Enter the prescribing physician's correct seven-digit Virginia Medicaid Provider Number.

Block 11 **Brand Necessary (B/N)** - Enter an "X" in this block **only** when the prescribing physician certifies "Brand Necessary" in his or her own handwriting on a prescription for a brand name drug that identifies with a MAC drug.

Unnumbered Block **Pharmacist's Use Block** - This block is to be used in the following circumstances:

- When a restricted recipient has a prescription filled by a pharmacy other than the designated pharmacy. In this case, the non-designated pharmacy enters the letters "ER" in the left side of the Pharmacist's Use block adjacent to Block 11 and writes a description of the life-threatening emergency or includes in the bottom portion of the claim the designated pharmacy's Medicaid ID number and an explanation of why the prescription was filled, in the bottom portion of the claim.

- When the claim is for a pregnancy-related drug and the prescribing physician has so indicated on the prescription. In this case, the pharmacy enters the letters "PG" in the left side of the Pharmacist's Use block adjacent to Block 11. This will prevent the claims payment system from automatically deducting a copayment amount for this prescription. The pharmacist must not collect a copayment from the recipient for these prescriptions. This exemption does not apply after the pregnancy is terminated.

Remarks Section - In the appropriate spaces, enter the following:

- If a non-specific drug code has been used in Block 6, describe the drug product including the NDC Number of all ingredients, or each ingredient if a compound, and identify the manufacturer(s) or distributor(s);

- The date of the remittance voucher on which the claim being voided or adjusted was approved;

- The amount of the charge that was allowed by Medicaid (taken from the remittance voucher);

- The amount of the non-covered charges - This amount is computed by subtracting the allowed amount from the charge amount entered in Block 9;

- Reason for adjustment - If applicable, check the appropriate reason. If "Other" is checked, explain in the space provided;

and

- Reason for void - If applicable, check the appropriate reason. If "Other" is checked, explain in the space provided.

Unnumbered Space — **Signature and Date** - Enter the signature of the provider or the provider's agent and the date signed.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

If the Medicare Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Practitioner
Department of Medical Assistance Services
P. O. Box 27444
Richmond, Virginia 23261-7444

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

See the "Exhibits" section at the end of this chapter for a sample of this form.

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE, DMAS-30 (REVISED 4/96)

Purpose To provide a method of billing Medicaid for Medicare deductible and coinsurance.

Explanation

Block 1 **Transmission Code** - This is a number assigned and preprinted by the Department of Medical Assistance Services.

Block 2 **Provider Identification Number** - Enter the seven-digit provider identification number assigned by Medicaid and the provider name and address.

Block 3 **Recipient's Name** - Enter the last name and the first name of the patient as they appear on the recipient's eligibility card.

Block 4 **Recipient Identification Number** - Enter the 12-digit number taken from the recipient's eligibility card.

Block 5 **Patient Account Number** - If a numbering system is used by the provider for patient identification, enter the patient's number in this block. This number will appear on the Remittance Voucher preceding the name. If no such system is used, leave this block blank.

Block 6 **Recipient HIB Number** (Medicare) - Enter the recipient's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** - If the Carrier Code on the recipient's Medicaid eligibility card is blank, indicating no other coverage or contains the code 001 (Medicare), check Block 2.

- **Code 3 - Billed and Paid** - When a recipient has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and

coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the recipient has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate code:

00-09	Unassigned
11	Office
12	Home
10, 13-20	Unassigned
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room—Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
27-29	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
30, 35-39	Unassigned
41	Ambulance—Land
42	Ambulance—Air or Water
40, 43-49	Unassigned
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
50, 57-59	Unassigned
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
60, 63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-69	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic

70, 73-79	Unassigned
81	Independent Laboratory
80, 82-89	Unassigned
99	Other Unlisted Facility
90-98	Unassigned

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

Accident - Possible third-party recovery
Emergency - Not an accident
Other - If none of the above

Block 11 **Type of Service** - Enter the appropriate code describing the type of service:

0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services
A	Used DME
B	High Risk Screening Mammography
C	Low Risk Screening Mammography
D	Ambulance
E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Psychological Therapy
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy
Y	Second Opinion on Elective Surgery

Z Third Opinion on Elective Surgery

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code which was billed to Medicare. Each procedure must be billed on a separate line. For practitioner services, if applicable, follow the five-digit code with a hyphen and a procedure modifier. Procedure modifiers can be obtained from the American Medical Association *Physicians' Current Procedural Terminology* (CPT) book and the Health Care Financing Administration *Common Procedure Coding System* (HCPCS) book. If there was no procedure code billed to Medicare, leave this block blank.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.

Block 12 **Date of Admission** - Leave blank.

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (through), e.g., 01-01-99 to 01-31-99.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and

Disposition Information as explained above may either be typed or legibly handwritten. If an explanation regarding this claim is necessary, the "Remarks" section may be used. Separate and forward the original copy, along with a copy of the EOB attached, in the envelope supplied by the Program. Retain the provider's copy in the office files. Mail the completed claims to:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS-31 (REVISED 6/96)

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, rejected, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** - If not preprinted, enter the seven-digit number assigned by DMAS. The provider name and address should also be entered if not preprinted.

This number is preprinted on the invoice with the name and address of the provider and the transmission code. Since the name of the provider and the provider identification number are required before an invoice can be processed, the invoice should never be submitted without these two items of information.

Block 2A **Reference Number** - Enter the reference number taken from the Title XVIII Deductible and Coinsurance Remittance Voucher for the line of payment needing adjustment. The reference number (nine digits) follows the recipient's eligibility number on the remittance voucher. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Blocks 3-20 Refer to the instructions for DMAS-30 for the completion of these blocks.

Remarks This section of the invoice should be used to give a brief explanation of the change needed.

Signature The signature of the provider or the authorized agent and the date signed are required.

Mechanics and Disposition **The form may either be typed or legibly handwritten**. Separate and forward the intermediary copy in the preaddressed envelope supplied by the Program. Retain the provider's copy in the office files.

The correct address is:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

INSTRUCTIONS FOR PHARMACY BILLING FOR VACCINES OR SERVICE DAY RATES FOR HOME IV SERVICES ON THE HCFA-1500 (12-90) CLAIM FORM

The following instructions have numbered items corresponding to fields on the HCFA-1500 (12-90) that are either required or conditional for payment. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number—Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name—Enter the name of the recipient receiving he service as it appears on the identification card.**

10	**REQUIRED**	**Is Patient's Condition Related To:—Enter an "X" in the appropriate box. (The "place" is not required.)** **a. Employment?** **b. Auto Accident?** **c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form when procedure modifier "22" (unusual services) is used.**
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury—Enter the appropriate and current ICD-9-CM diagnosis code which describes the nature of the condition for which the service was rendered.**
22	**CONDITIONAL**	**Medicaid Resubmission—Required for adjustments and voids. See the instructions for Adjustment and Void invoices.**
24A		**REQUIRED Dates of Service—Enter the from and through dates in a two-digit format for the month, day, and year (e.g., 01/01/99).**
24B	**REQUIRED**	**Place of Service—** **For Vaccinations -Enter the two-digit HCFA code of "11" (office).** **For Home IV Service Day Rate - Enter the two-digit HCFA code of "12" (patient's home)**
24C	**REQUIRED**	**Type of Service—Enter the one-digit HCFA code of "1" (medical care).**
24D	**REQUIRED**	**Procedures, Services or Supplies** **CPT/HCPCS—** **For immunizations -Enter the five-character CPT/HCPCS Code which describes the immunization provided.** **For Home IV Service Day rates - Enter the five-character CPT/HCPCS Code for the appropriate therapy, as follows:** **Service day rates, by type of therapy, for basic components as delineated in Chapter IV* are:**

Z7779	**Pharmacy - Hydration Therapy**	**$ 8.00**
Z7780	**Pharmacy - Chemotherapy**	**25.00**
Z7781	**Pharmacy - Pain Management Therapy**	**12.00**
Z7782	**Pharmacy - Drug Therapy**	**27.00**
Z7783	**Pharmacy - TPN Therapy**	**150.00**

***Payment for the active ingredient is billed separately using the Daily Pharmacy Drug Claim Ledger form (DMAS-173), Point-of-Service (POS) on-line billing, or other approved electronic billing method.**

Modifier—Enter a "22" modifier as necessary:

For vaccinations -ONLY if documentation is attached to the claim to support the immunization being billed (e.g., medical justification, justification to waive one year timely filing).

For Pharmacy Service Day Rates associated with Home IV Therapies: This is a required field.

24E REQUIRED — **Diagnosis Code—Enter the entry identifier of the ICD-9-CM diagnosis code listed in Locator 21 as the primary diagnosis.**

24F REQUIRED — **Charges—Enter the acquisition cost of the immunization. For Home IV Therapies- Enter the appropriate charges as noted above in Field 24D.**

24G REQUIRED — **Days or Unit—Enter the number of times the procedure, service, or item was provided.**

24H CONDITIONAL — **EPSDT or Family Plan—Enter a code of "1" if the vaccine being billed is a vaccine provided to an individual age 19 or 20.**

24I CONDITIONAL — **EMG (emergency)—Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**

24J CONDITIONAL — **COB (Primary Carrier Information)—Enter the appropriate code.**

2 No Other Carrier
3 Billed and Paid
5 Billed, No Coverage*

***All claims submitted with a COB code of 5 will be denied unless there is an attachment to the claim documenting one of the following:**

- **The Explanation of Benefits (EOB) from the primary carrier; or**
- **A statement from the primary carrier that there is no coverage for this service; or**
- **An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is an immunization claim and the other coverage is dental); or**
- **A statement from the pharmacy indicating that the primary insurance has been canceled.**
- **Claims received with no attachment will be denied for reason 495 "Other Insurance Information Missing."**

24K CONDITIONAL — **Reserved for Local Use—Enter the dollar amount received from the primary carrier if Block 24J is coded "3."**

26 OPTIONAL — **Patient's Account Number—Seventeen alphanumeric characters are acceptable. This information will print on the remittance voucher and could assist in identifying the patients for whom the bill is and for whom the payment is.**

31 REQUIRED — **Signature of Physician or Supplier Including Degrees or Credentials—The provider or agent must sign and date the invoice in this block.**

33 REQUIRED — **Physician's, Supplier's Billing Name, Address, ZIP Code and Phone #—Enter the pharmacy's billing name, address, ZIP Code, and phone number as they appear in the Virginia Medicaid provider record. Enter the seven-digit Virginia Medicaid provider number in the PIN # field. Ensure that the provider number is distinct and separate from the phone number or ZIP Code.**

INSTRUCTIONS FOR THE COMPLETION OF THE HCFA-1500 (12-90) AS AN ADJUSTMENT INVOICE

The adjustment invoice is used to change information on a paid claim. Follow the instructions for the completion of the HCFA-1500 (12-90) claim form, except for the locator indicated below:

Locator 22 Medicaid Resubmission

Code—Enter the three-digit code identifying the reason for the submission of the adjustment invoice.

523 Primary Carrier has made additional payment
524 Primary Carrier has denied payment
527 Correcting date of service
528 Correcting procedure code
530 Correcting charges
531 Correcting units/visits/studies/procedures
532 IC reconsideration of allowance, documented
533 Correcting referring, prescribing provider identification number

Original Reference Number—Enter the nine-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 (12-90) submitted as an Adjustment Invoice (each line under Locator 24 is one claim).

INSTRUCTIONS FOR THE COMPLETION OF THE HCFA-1500 (12-90) AS A VOID INVOICE

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the HCFA-1500 (12-90) claim form, except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code—Enter the three-digit code identifying the reason for the submission of the void invoice.

542 Original claim has multiple incorrect items
544 Wrong provider identification number
545 Wrong recipient eligibility number
546 Primary carrier has paid DMAS maximum allowance
547 Duplicate payment was made
548 Primary carrier has paid full charge
551 Recipient is not my patient
552 Void is for miscellaneous reasons
560 Other insurance is available

Original Reference Number—Enter the nine-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required on each HCFA-1500 (12-90) submitted as a Void Invoice (each line under Locator 24 is one claim).

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, microfilmed, assigned a reference number and entered into the system, it is placed in one of the following categories:

- Rejects - The claim cannot be processed for some reason and is returned to the provider. These claims should be resubmitted on a new invoice with corrected data.

- Remittance Voucher

  - **Approval** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).

  - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.

  - **Pending** - Claim placed in a pended status for manual adjudication (the provider must not resubmit)

- No Response - **If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.**

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

REMITTANCE VOUCHER

General Information

The remittance voucher is a computer-generated notice sent to providers showing the status of claims received by the Virginia Medicaid Program. Paid, denied, pending, and adjusted claims are reported on the remittance voucher document. If there are questions about a particular claim, the following procedure may be followed to provide the necessary answers:

- The remittance voucher should be the first source of reference. Please note the specific messages relating to the claim status.

  If the claim is pending, no action is required by the provider. The claim is being reviewed manually or by the system.

  Please note if one of the following symbols is printed for a particular claim:

* The asterisk relates to a computer edit which serves to alert the provider to review the particular claim for a possible adjustment either in the charge or the reporting unit. If the data submitted are correct, no additional action is required by the provider.

\# The number sign relates to payment for a legend drug dispensed to a recipient and does not include the dispensing fee, which has been paid on a prior claim for the same drug in the same month.

- Verify all data submitted to be correct (e.g., Drug Code).
- Review the billing procedures or policies relating to covered drugs.
- Contact the Medicaid HELPLINE for assistance.

Definitions of Headings

The definitions of headings are as follows:

- **Approved** - Payments are made.
- **Debit** - A refund is made due to an error in a pharmacy's account. If a claim has been paid incorrectly, the original payment is deducted from the account in the credit portion and added correctly in the debit portion.
- **Credit** - Money is being subtracted due to an error in a pharmacy's account. A duplicate payment or a payment for services not covered will be reflected in the credit portion.
- **Pending** - A claim is being processed and requires a system or manual review before payment is made. Allow a sufficient period of time for these to be resolved before making inquiries.
- **Paid by Patient/Other Ins** - A copayment of $1.00 or $2.00, when appropriate, will be listed as of September 1, 2002.
- **Denied** - Claims which are not paid for some specific reason; note special messages.
- **Date of Adm.** - Date of service for pharmacy claims.
- Other headings are self-explanatory.

Special Messages

Participating pharmacies should monitor their remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures
- Sharing clarification on a concern expressed by a provider

HELPLINE

The Medicaid HELPLINE telephone numbers are:

786-6273	Richmond Area
1-800-552-8627	All Other Areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays.

BILLING INQUIRIES

Mail questions concerning billing problems, covered benefits, DMAS policy or remittances, and any miscellaneous correspondence to:

Department of Medical Assistance Services
Provider Inquiry Unit
Division of Program Operations
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Direct questions concerning recipient eligibility to the **Audio Response System (ARS)** at the following numbers:

1-800-884-9730	
(804) 965-9732	Richmond and surrounding counties
(804) 965-9733	Richmond and surrounding counties

CORRESPONDENCE AND WRITTEN INQUIRIES

All correspondence and written inquiries or submission of requested information to DMAS should include a telephone number and the name of a contact person at the pharmacy in addition to the Medicaid pharmacy provider identification number.

REPLENISHMENT OF BILLING MATERIALS

Pharmacy claim forms, as well as all FAMIS and Medicaid recipient brochures, will continue to be provided via our mailing contractor, Commonwealth-Martin. You may contact the DMAS Order Desk at 1-804-780-0076, or you may fax them at 1-804-780-0198. You MUST use original forms provided by DMAS for claims submissions. Black and white reproductions, if submitted, will be returned without processing.

Copies of the pharmacy claim form appearing on-line are for information only and may not be downloaded and reproduced for claims submission. Only claims printed in scannable

red drop-out ink will be processed for payment. All claims forms should be filled out using only blue or black ink for data entry.

Pharmacy claim forms (173-R02/01) should be returned to:

Department of Medical Assistance Services
Pharmacy
P.O. Box 27445
Richmond Virginia 23261-7445

Pharmacy services billed on HCFA 1500 claim forms should be sent to:

Department of Medical Assistance Services
Pharmacy
P.O. Box 27444
Richmond Virginia 23261-7444

COMPUTER-GENERATED INVOICES

Providers wishing approval to submit computer-generated invoices, either on continuous forms, diskette or magnetic tape, should write to:

Coordinator
Electronic Media Claims
FIRST HEALTH Services Corporation
Post Office Box 26228
Richmond, Virginia 23230

EXHIBITS

PLEASE PRINT CLEARLY

Provider Medicaid ID Number
01

Virginia Department of Medical Assistance Services
PHARMACY CLAIM FORM

Patient 1

Patient's Last Name, First Name 02	Patient's Medicaid ID Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
1								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient 2

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
2								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient 3

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
3								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient 4

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
4								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient 5

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
5								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

Patient 6

Patient's Last Name, First Name 02	Patient's Medicaid Number 03	Sex 04	Birth Date MM DD CCYY 05	Level of Svc 06	Days Supply 07	Refill 08	DAW 09	Patient Loc 10
6								

Resubmission Code 11	Original Reference Number 12	Prescription Number 13	Date Dispensed MM DD CCYY 14	NDC Number 15	Metric Decimal Quantity 16	Unit Dose 17

Exempt 18	Prior Authorization Number 19	Prescriber's Medicaid ID Number 20	Diagnosis 21	Amount Billed 22	COB 23	Payment by Primary Carrier 24
				$		$

25 Comments: _____

Provider Name, Address and Telephone Number

26

This is certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal or State laws.

Signature of Provider or Representative

27 _____

DMAS-173 R 2/01

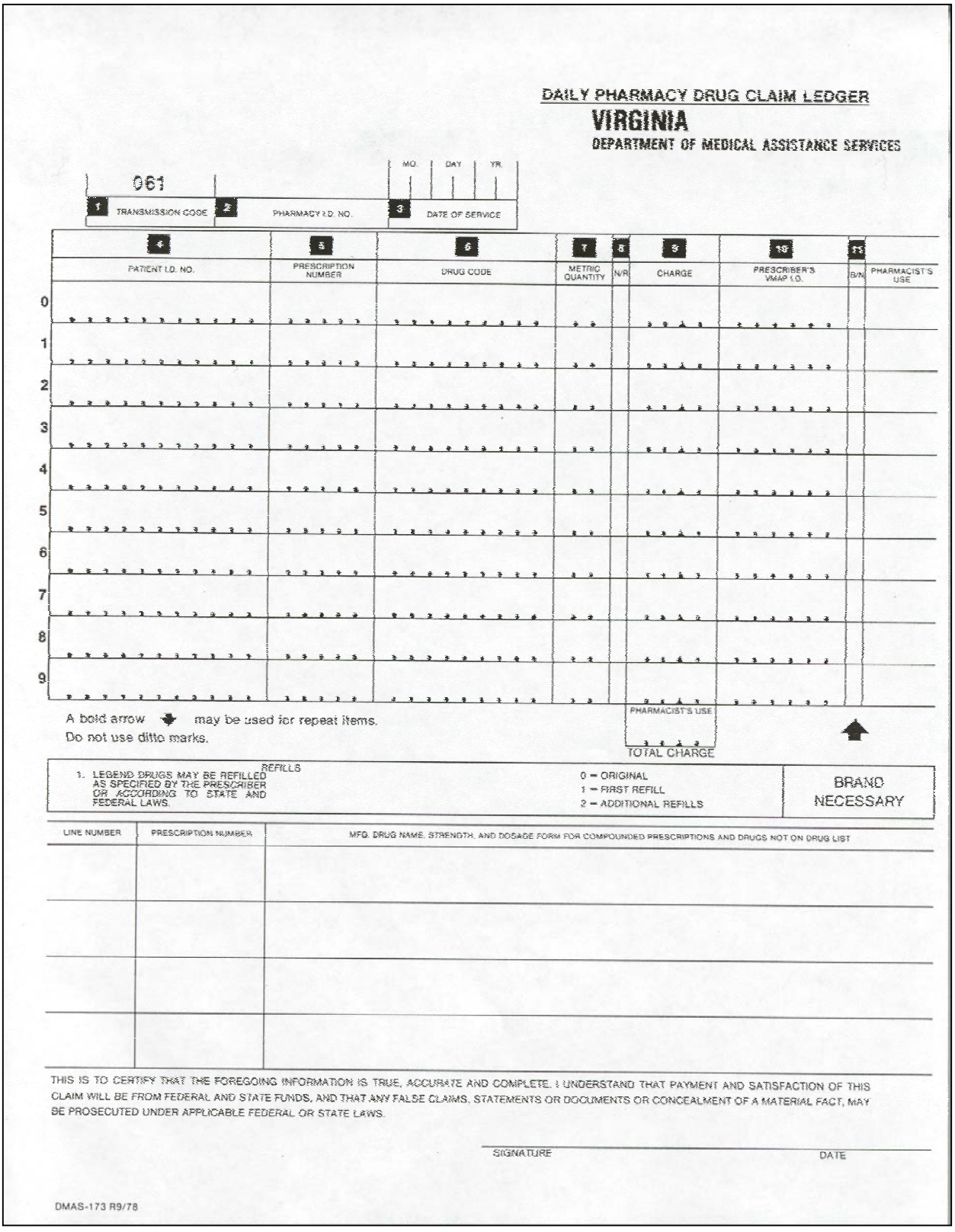
Date (mm-dd-cc-yy): 2 0

PHARMACY CLAIM FORM COMPLETION

The following instructions describe each field by referencing the field number found in the left corner of the claim form data elements.

Field # Narrative Description

1. Enter your Medicaid provider ID number.
2. Enter the patient's last name and first name.
3. Enter the 12-digit Medicaid patient ID number.
4. Enter the patient's sex. M = Male, F = Female.
5. Enter the patient's birth date. Use MMDDCCYY format.
6. Enter the level of service code if appropriate. 01 = Patient consultation, 02 = Home delivery, 03 = Emergency, 04 = 24-hour service, 05 = Patient consultation regarding generic product selection.
7. Enter the days supply.
8. If this is an original prescription, enter 00. If this is a prescription refill, indicate the number of the refill. Valid values are 00 to 99.
9. Enter the Dispense as Written override code of "1" for prescriptions for which "Brand Necessary" is indicated in accordance with the law and Medicaid policy. The value should be used only when the prescribing physician certifies "Brand Necessary" in his or her own handwriting for a prescribed brand name drug that is generically available.
10. Enter the patient's location. Valid values are: 00 = Not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice.
11. **Use this field only if an adjustment or void is being requested.** Enter the appropriate code if requesting the adjustment or void of a previously paid claim. Valid values are: 1033 = Correcting prescriber ID, 1034 = Correcting metric quantity, 1035 = Correcting drug code,1036 = Allowance for Rx less than pharmacy cost, (wholesale invoice attached), 1053 = Other, 1052 = Void.
12. **Use this field only if an adjustment or void is being requested.** Enter the reference number of the claim that is to be voided or adjusted.
13. Enter the prescription's 7-digit Rx number, If Rx number is less than 7-digit, please add a leading "0".
14. Enter the date dispensed in MMDDCCYY format.
15. Enter the 11-digit National Drug Code (NDC), Health Related Item code (HRI), or Universal Package Code (UPC) which corresponds to the product dispensed. Be certain all NDCs entered are current. Confirm refill NDCs are correct.
16. Indicate the metric decimal quantity (e.g., 2.5) of the product using the appropriate unit of measure (each, gram or milliliter).
17. Enter the appropriate unit dose code. Valid values are: 0 = Not specified, 1 = Not unit dose, 2 = Manufacturer's unit dose, 3 = Pharmacy unit dose, 4 = Unit dose for nursing homes.
18. Enter the exemption indicator if appropriate. 02 = Medical certification, 03 = EPSDT, 04 = Exemption from Co-pay, 05 = Exemption from prescription limits, 06 = Family planning indicator, 08 = Payer defined exemption.
19. Enter the 11-digit prior authorization number if required.
20. Enter the prescriber's Medicaid provider ID number.
21. Enter the ICD-9CM diagnosis code if appropriate. **If using a 4 or 5-digit code number, do not enter the decimal point.**
22. Enter the usual and customary charge for the prescription. This field should include the dispensing fee.
23. Enter the coordination of benefits code. Valid values are: 02 = No other carrier, 03 = Billed and paid, 05 = Billed, No coverage.
24. Enter the dollar amount paid by the primary payer if coordination of benefits applies.
25. Enter comments, if any (i.e., "Claim #3 used for high cholesterol")
26. Enter the Pharmacy's name, address and telephone number.
27. Note the certification statement on the claim form, and sign and date the claim form.



DAILY PHARMACY DRUG CLAIM LEDGER

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

061

1 TRANSMISSION CODE | 2 PHARMACY I.D. NO. | 3 DATE OF SERVICE (MO. DAY YR.)

	4 PATIENT I.D. NO.	5 PRESCRIPTION NUMBER	6 DRUG CODE	7 METRIC QUANTITY	8 N/R	9 CHARGE	10 PRESCRIBER'S VMAP I.D.	11 B/N	PHARMACIST'S USE
0									
1									
2									
3									
4									
5									
6									
7									
8									
9									

A bold arrow ➧ may be used for repeat items.
Do not use ditto marks.

PHARMACIST'S USE

TOTAL CHARGE

1. LEGEND DRUGS MAY BE REFILLED AS SPECIFIED BY THE PRESCRIBER OR ACCORDING TO STATE AND FEDERAL LAWS.

REFILLS
0 = ORIGINAL
1 = FIRST REFILL
2 = ADDITIONAL REFILLS

BRAND NECESSARY

LINE NUMBER	PRESCRIPTION NUMBER	MFG. DRUG NAME, STRENGTH, AND DOSAGE FORM FOR COMPOUNDED PRESCRIPTIONS AND DRUGS NOT ON DRUG LIST

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

DMAS-173 R9/78

The Daily Pharmacy Drug Claim Ledger is to be used daily to record only those prescriptions filled on the date entered in Block 3. All entries must be numeric in blocks 1-10.

INSTRUCTIONS FOR COMPLETING DAILY PHARMACY DRUG CLAIM LEDGER (DMAS - 173)

Block 1: Preprinted.

Block 2: Provider I.D. Number - If not preprinted, enter the seven- (7-) digit provider identification number assigned by Virginia Medicaid.

Block 3: Date of Service - Enter the date the prescriptions were dispensed using 2 digits each for month, day, and year, e.g. 07-09-78.

Block 4: Recipient Number - Enter the twelve- (12-) digit Virginia Medicaid identification number for the recipient receiving the service.

Block 5: Prescription Number - Enter the prescription number assigned by the pharmacy (6 digits).

Block 6: Drug Code - Enter the 10-digit NATIONAL DRUG CODE of the drug dispensed as assigned by the drug manufacturer (must be 10 digits).

Block 7: Metric Quantity - Enter the quantity dispensed using 3 digits; no decimals or fractions. Refer to code listing for reporting unit.

Block 8: N/R - New or original prescriptions enter O; first refill, 1; additional refill, 2.

Block 9: Charge - Enter usual and customary charge.

Block 10: Prescriber's I.D. - Enter the physician's seven- (7-) digit Virginia Medicaid provider number.

Block 11: Leave blank, except when physician certifies BRAND NECESSARY for a specific Brand Name drug, enter an "X".

For Pharmacist's Use: Self-explanatory.

TOTAL CHARGE - For pharmacist's use.

Block 12: Signature - The signature of the provider or agent.

Block 13: Date - Enter the date signed.

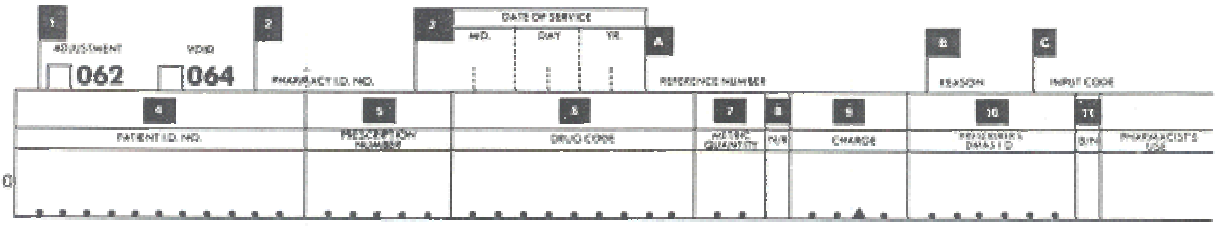
NOTE: Use the section at the bottom of the form to fully describe the compounded prescription and the non-coded prescription.

Submit original form using the Pharmacy Envelope supplied by the Department.

The other two copies are for your files or use if needed.

DAILY PHARMACY DRUG CLAIM LEDGER

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



THIS IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS

_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

AMOUNT ALLOWED _____ NON-COVERED CHARGE _____

REASONS FOR ADJUSTMENT:

_____ CORRECTING PRESCRIBER I.D.
_____ CORRECTING METRIC QUANTITY
_____ CORRECTING DRUG CODE
_____ ALLOWANCE FOR THIS PRESCRIPTION WAS LESS THAN MY COST.
_____ DRUG COST INCREASE; WHOLESALE INVOICE SUPPORTING MY COST ATTACHED
_____ OTHER: _____

_____

REASONS FOR VOID:

_____ USED INCORRECT RECIPIENT NUMBER
_____ OTHER: _____

_____

ADJUSTMENT

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

_____
SIGNATURE DATE

DMAS-228 (8/78)

INTERMEDIARY COPY

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

091

1 TRANSMISSION CODE | 2 PROVIDER I.D. NO.(7)

0

3 RECIPIENT'S LAST NAME	FIRST NAME	4 RECIPIENT I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RECIPIENT'S HIB NUMBER (MEDICARE)

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)	8 TYPE COVERAGE (MEDICARE)	9 DIAGNOSIS	9A PLACE OF TREAT. (2)	10 ACCIDENT EMERG INDICATOR	11 TYPE SERV (1-2)	11A PROCEDURE CODE (5)	11B VISITS UNITS STUDIES (3)	12 DATE OF ADMISSION	13 STATEMENT COVERS PERIOD
☐ 2 NO OTHER COVERAGE ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COVERAGE	☐ A ☐ B			☐ ACC ☐ EMER ☐ OTHER				MO (2) DAY (2) YEAR (2)	FROM MO (2) DAY (2) YEAR (2) THRU MO (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE	15 ALLOWED BY MEDICARE	16 PAID BY MEDICARE	17 DEDUCTIBLE	18 COINSURANCE	19 PAY BY CARRIER OTHER THAN MEDICARE	20 PATIENT PAY AMOUNT LTC ONLY

1

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14 CHARGES TO MEDICARE	15 ALLOWED BY MEDICARE	16 PAID BY MEDICARE	17 DEDUCTIBLE	18 COINSURANCE	19 PAY BY CARRIER OTHER THAN MEDICARE	20 PATIENT PAY AMOUNT LTC ONLY

REMARKS: IDENTIFY LINE ITEM TO WHICH REMARKS REFER

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SIGNATURE DATE

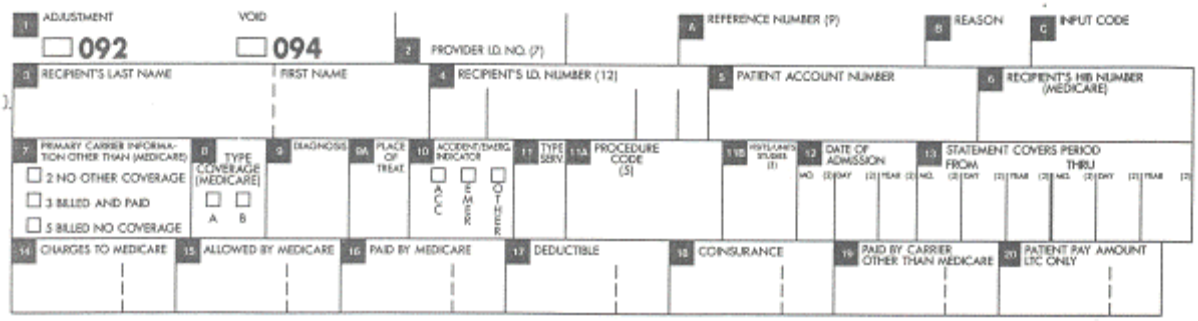
ORIGINAL COPY

DMAS - 30 R 4/96

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

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SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/96

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

METRIC EQUIVALENTS FOR MOST FREQUENTLY USED STRENGTHS AND QUANTITIES

Definitions:

gr	=	grain	mg	=	milligram
cc	=	cubic centimeter	GM	=	gram
oz	=	ounce	ml	=	milliliter
lb	=	pound			

Approximate Apothecary Equivalents			Metric Measure					
1/300	gr	=	0.2	mg				
1/120	gr	=	0.5	mg				
1/100	gr	=	0.6	mg				
1/8	gr	=	8	mg				
1/6	gr	=	10	mg				
1/3	gr	=	20	mg				
1/4	gr	=	15	mg	(16 mg)			
3/8	gr	=	25	mg				
1/2	gr	=	30	mg	(32 mg)			
3/4	gr	=	50	mg				
1	gr	=	60	mg	(64 mg)			
1-1/2	gr	=	100	mg		=	0.1	GM
2	gr	=	120	mg				
3	gr	=	200	mg				
3-3/4	gr	=	250	mg		=	0.25	GM
5	gr	=	300	mg	(325 mg)	=	0.3	GM
7-1/2	gr	=	500	mg		=	0.5	GM
10	gr	=	600	mg				
15	gr	=	1000	mg		=	1.0	GM
1/4	oz	=	7.5	ml	or 7.5	GM		
1/2	oz	=	15.0	ml	or 15.0	GM		
1	oz	=	30.0	ml	or 30.0	GM		
4	oz	=	120.0	ml	or 120.0	GM		
8	oz	=	240.0	ml	or 240.0	GM		
16	oz (Pint)	=	480.0	ml	(473 ml)			
1	cc	=	1	ml				
1	lb	=	454	GM				